TREATMENT RECORD

MEDICAL RECORD

R ARM INJURY/PAIN

WBC PLT HCT

☐ CHEM 7

Na Cl BUN GLUCOSE K CO_2 CR

☐ PT ____ TROPONIN ____
INR ____ LIPASE ____
☐ PTT ____ BHCG ____

☐ ADDITIONAL LABS: ____

☐ URINE Gluc ____
Bili ____
Ketones ____
pH ____
sp. gr ____
Protein ____
Hgb ____
Nitrites ____
Leuk est ____
WBC ____ RBC ____
☐ Bacteria ☐ Squamous
☐ Preg ☐ POS ☐ NEG

ARTERIAL BLOOD GASES	
pH	
pCO_2	
pO_2	
O_2Sat	
Amt O_2 L/M	

PULSE OXIMETER	% SAT
TIME	981

☐ HYPOXIA ☐ NON HYPOXIC

LABORATORY

PRE-PROCEDURE TIME OUT: PROCEDURE ____ VERIFIED: PATIENT IDENTIFICATION ☐,
PROCEDURE TYPE ☐, SITE MARKED ☐ PRINT ____ RN ____ MD

PROGRESS NOTES PROCEDURES

EKG: ____
☐ Reviewed c Cardiologist

X-RAYS: (R) wrist/Forearm: Non displaced distal radius fx
☐ Reviewed c Radiologist

SERVICE	TIME CALLED	SERVICE	TIME CALLED

CONSULTS

☐ MEDICAL RECORD REQUESTED AT ____ AM / PM ☐ MEDICAL RECORD REVIEWED AT ____ AM / PM
TIME: 0630 I EXAMINED THE PATIENT, I REVIEWED THIS CHART, I DISCUSSED THE CASE WITH THE
RESIDENT, DR. Marques-Baptiste
agree c. resident assessment, note often

ATTENDING

INITIAL IMPRESSION:
PLAN:
SELF PAY
ENDORSED TO DR. ____ AT ____

DIAGNOSIS:

	CODE
1. Contusion forearm	
2.	
3.	

DISCHARGE ☐
ADMISSION ☐
☐ SERVICE ☐ PRIVATE
ATTENDING: ____
RM: ____
TIME ☐ AM ☐ PM

DIAGNOSIS

CONDITION

☐ IMPROVED ☐ GUARDED ☐ EXPIRED
☐ STABLE ☐ CRITICAL

DISPOSITION

☐ TREATED AND RELEASED
☐ LEFT PRIOR TO MSE/WALKOUT
☐ LEFT PRIOR TO DISCHARGE/ELOPEMENT
☐ LEFT AMA
☐ TRANSFERRED TO ____
☐ DOA / DIED IN ED TIME ____ ME CASE # ____

MD NAME (Signature)	ID NUMBER	MD NAME (Signature)	ID NUMBER	DIAGNOSED & TREATED IN MY PRESENCE ATTENDING MD NAME (Signature)	ID NUMBER
	91624				19605
MD NAME (Print)		MD NAME (Print)		ATTENDING MD NAME (Print)	
Marques-Baptiste				Shatter	

43580 (12/03)

St. Lukes
1111 Amsterdam Avenue
NY, NY 10025

Emergency Department
212-523-3335

St. Luke's Roosevelt
Continuum Health Partners, Inc.

Assessment Sheet

Patient: Thomas,
Phone: (718)210-33
Unit: Main Ed
DOB: 05/26/1937
MR #: 200004371794
Chart #: ED694398
ACT #: 000449139617
Sex: Female
Age: 69
Address: 99-10 60TH AVENUE #5J, CORONA, NY 11368

Complaint: **R Arm Injury/pain**
Arrival Date/Time: **05:26 12/29/2006**
Arrived by: **Walk-in**
Mobility:
Accompanied By: **Friend/Family**
Last Date Seen: **07/07/2006 08:07**
Emergency Resident Physician: **MARQUES, ANDREIA**

Triage Acuity: **2 - Urgent**
Primary Insurance: **OXFORD MEDICARE**
Secondary/Tertiary Insurance: **MEDICAID OF NY/**
Referring Phys/Facility:
PMP: **Unassigned,**
Emergency Attending Physician: **STRATTON, JENNIFER B**

Complaint Code:

Triage Nurse: **MAURAIS, RN, MARTIN**
Primary Nurse: **FUNCK, RN, ERIKA**

Treatments PTA:
Travel History: **Travel outside US <= 10 days: No. Contact with traveler <= 10 days: No.**
Symptoms in the past 7 days: None of the above. Contact with birds at risk: No. Travel History Note: . Hand hygiene: No. Mask applied: No.

Special Needs:

Past Medical Hx: **Diabetic Insulin Dependent, Hypertension**
Tetanus Hx:
Social Hx:
Weights:

LMP Date:

Medications

Medication	Dosage	Freq	Prescribing Phys	Started
Insulin				
Atenolol				
Hydrochlorothiazide				
Norvasc				

Allergy

Allergy	Allergic Reaction
***No Known Allergies**	

Vital Signs

Info	Time	Temp	Blood Pressure	Pulse	Resp
MM	**05:30**	**98.6**	**200/105 ,,**	**82**	**18**

Pain

Time	Scale
05:30	**4/10**

Pulse Ox.

Time	%	Concentration	Peak Flow
05:30	**98**		

Glasgow Coma

Time	Score

Disposition Information
Primary Diagnosis: **Fx closed radius, head**
Disposition: **Disch - Home**
Discharge Time: **11:00 12/29/2006**
RN Report Called By:
RN Report Given To:
MD Report Called By:
MD Report Given To:
Follow-up Care: **CATALANO, LOUIS**
Appt Date/Time:
Disability Statement:
Prescriptions:
Discharge Instructions: **FRACTURED EXTREMITY, FRACTURED HAND, SPLINT CARE**

Secondary Diagnosis:
Discharge Acuity: **2 - Urgent**
Admit To Team:
Admit To Floor/Room: /
Service/Private:
Admit To Physician:
Admit - Resident:
Admit - Intern:
Family Notification:

St. Lukes
1111 Amsterdam Avenue
NY, NY 10025

Emergency Department
212-523-3335

St. Luke's Roosevelt

Continuum Health Partners, Inc.

Assessment Sheet

(S)

Name: Thomas, A
Phone: (718)210-335
Unit: Main Ed

MR #: 200006371794
Chart #: ED694398
ACT #: 000449139617

DOB: 05/26/1937
Sex: Female
Age: 69

Address: 99-10 60TH AVENUE #5J, CORONA, NY 11368

Initial Triage Info
05:31 12/29/2006 - Initial Triage Info - MAURAIS, RN MARTIN
Chief Complaint: R Arm injury/pain
Presenting Complaints: Arm pain- right
Duration: 1, days
Quick Assessment: Alert, AIRWAY intact, AIRWAY handling secretions, -Alert and Oriented x 3
Significant Neg. Findings: Denies back pain, Denies chest pain, Denies syncope, Denies shortness of breath
Initial Triage Acuity: 2 - Urgent
Mode of Arrival: Walk-in
Accompanied by: Friend/Family
Travel outside US <= 10 days: No
Contact with traveler <= 10 days: No
Symptoms in the past 7 days: None of the above
Contact with birds at risk: No
Hand hygiene: No
Mask applied: No
Note: Was pushed, fell against some shelves at a store, complaining of right arm pain, swelling. No obvious deformity, but tender, swollen. Pos pulses.

PMH/Current Meds/Allergies
05:26 12/29/2006 - Allergy Information - MAURAIS, RN MARTIN
Allergy: *No Known Allergies
05:27 12/29/2006 - Medicine - MAURAIS, RN MARTIN
Medication: Insulin
Medication: Atenolol
Medication: Hydrochlorothiazide
Medication: Norvasc
Note: quinapril glimepiride precose
05:27 12/29/2006 - Past Medical History - MAURAIS, RN MARTIN
Medical history: Diabetic Insulin Dependent, Hypertension
Surgical history: -None
Special Needs: -Potential Educ. Barrier-none
11:00 12/29/2006 - Medicine - MUKHERJEE KOUSTAV, MD
Medication: Insulin
Medication: Atenolol
Medication: Hydrochlorothiazide
Medication: Norvasc
Note: quinapril glimepiride precose

Medication Summary
Patient name, medication and allergy verification required at time of order.
Patient name, medication, allergy and DOB verification required before administration.
06:22 12/29/2006 - Percocet 1 po - STRATTON JENNIFER, MD
Medication Administered - 06:28 12/29/2006 by SCOTT, RN KASI
Medication: Percocet 1 po
Response to Medication - 06:28 12/29/2006 by SCOTT, RN KASI
Medication: Percocet
Pain Scale: 4/10

Lab Order & Result Summary
(None)

POCT Results
(None)

Xray Order & Result Summary
06:21 12/29/2006 - Forearm (R) - STRATTON JENNIFER, MD
09:19 12/29/2006 -- Final Order Results
Accession:
Procedure: FOREARM 2 VIEWS
Procedure Notes: 3-3338~ 69 yo female s/p fall on right arm.
with pain~~
Result:
Right wrist:
There is a transverse nondisplaced fracture of the distal radius
and the metaphyseal level. The distal radius and ulna are slightly separated, 2 mm. There is neutral ulnar variance.
The alignment of the carpal bones is normal.
Impression:
Nondisplaced distal radius fracture.
Discussed with Dr. Mukherje.
Right forearm:
Frontal and lateral projections were obtained.
There is no fracture along the shaft of the radius or ulna.
The
elbow joint appears normal, though not optimally centered.

06:22 12/29/2006 - Wrist 3vws (R) - STRATTON JENNIFER, MD
09:19 12/29/2006 -- Final Order Results
Accession:
Procedure: WRIST COMP 3+V
Procedure Notes: 3-3338~ 69 yo female s/p fall on right arm
with tenderness~~
Result:
Right wrist:
There is a transverse nondisplaced fracture of the distal radius
and the metaphyseal level. The distal radius and ulna are slightly separated, 2 mm. There is neutral ulnar variance.
The alignment of the carpal bones is normal.
Impression:
Nondisplaced distal radius fracture.
Discussed with Dr. Mukherje.
Right forearm:
Frontal and lateral projections were obtained.
There is no fracture along the shaft of the radius or ulna.
The
elbow joint appears normal, though not optimally centered.

EKG Results
(None)

IVs Given
(None)

Intake and Output
(None)

Assessment/Reassessment
05:30 12/29/2006 - Vital Signs - MAURAIS, RN MARTIN
Systolic: 200
Diastolic: 105
Pulse Rate: 82
Respirations: 18
Temperature: 98.6
Pain Scale: 4/10
Pulse Oximetry %: 98
05:31 12/29/2006 - Acuity - MAURAIS, RN MARTIN
Acuity: 2 - Urgent
05:34 12/29/2006 - Domestic Violence - GUILLORY, RN KELLY
Emotionally/Physically hurt?: No
Currently hurt by someone close?: No
Forced sex. activity in last yr?: No
Fear of partner or other?: No
History of Domestic Violence: No
05:34 12/29/2006 - Fall Risk Assessment - GUILLORY, RN KELLY
Low fall risk because: Ambulatory, steady gait, Independent and continent, No hx of falls, No orthostasis
07:32 12/29/2006 - Primary Survey - FUNCK, RN ERIKA
Airway: Patent and clear
Breathing: Present
Circulation: Warm and dry
Note: pt a&ox3, no acute distress at this time, awaiting x-ray
10:29 12/29/2006 - Reassessment - FUNCK, RN ERIKA
Note: pt remains a&ox3, no acute distress, awaiting x-ray results

CPP Risk Assessment
(None)

Other Orders
05:26 12/29/2006 - Initial Patient Orders - REG$
HIS Registration - REG$ at 12/29/2006 05:26
Begin Full Registration - STEELE, BA MILTON at 12/29/2006 05:36
Complete Full Reg. - STEELE, BA MILTON at 12/29/2006 05:59
05:31 12/29/2006 - Domestic Violence - MAURAIS, RN MARTIN
Record Dom. Violence Info - GUILLORY, RN KELLY at 12/29/2006 05:34
05:34 12/29/2006 - ER Physician Eval. - ALCANA, RN ANDRES

St. Lukes
1111 Amsterdam Avenue
NY, NY 10025

Emergency Department
212-523-3335

St. Luke's Roosevelt
Continuum Health Partners, Inc.
Assessment Sheet

Patient: Thomas, A DOB: 05/26/1937
Phone: (718)210-335 MR #: 200004371794 Sex: Female
Unit: Main Ed Chart #: ED694398 Age: 69
ACT #: 000449139617
Address: 99-10 60TH AVENUE #5J, CORONA, NY 11368

Evaluate Patient - MARQUES ANDREIA, MD at 12/29/2006 06:02
10:52 12/29/2006 - Disch - Home - MUKHERJEE KOUSTAV, MD
Medication Reconciliation - MUKHERJEE KOUSTAV, MD at 12/29/2006 11:00
Discharge Condition - FUNCK, RN ERIKA at 12/29/2006 11:00
Discharge Patient (completion not documented)
Co-pay cash collection (completion not documented)
Administrative Discharge (completion not documented)
Charting is Complete (completion not documented)

Discharge Information
10:52 12/29/2006 - Discharge Diagnosis - MUKHERJEE KOUSTAV, MD
Primary: Fx closed radius, head
10:55 12/29/2006 - Ref/App - MUKHERJEE KOUSTAV, MD
Appointment with: CATALANO, LOUIS
Phone: 212-523-7590
Follow up in: 5 days
10:57 12/29/2006 - Discharge Instructions - MUKHERJEE KOUSTAV, MD
Discharge Instruction: SPLINT CARE, FRACTURED EXTREMITY, FRACTURED HAND
10:57 12/29/2006 - Discharge Note - MUKHERJEE KOUSTAV, MD
Note: Please follow up with Dr. Catalano next week. Come back to the hospital if you have any concerns. Take the pain medication for pain as needed.
10:57 12/29/2006 - DOH Reporting - MUKHERJEE KOUSTAV, MD
DOH Reporting: Not Required
11:00 12/29/2006 - Discharge Condition - FUNCK, RN ERIKA
Acuity: 2 - Urgent
Condition: Stable
Mobility at Discharge: Ambulatory
Patient Teaching: Reviewed care plan with parent/guardian, Reviewed follow-up with parent/guardian, Reviewed DC instruct w/parent/guardian, Reviewed understanding w/parent/guardian
Mode of Discharge: Walking
Pain Scale: 1/10 - mild

Disposition Order
10:52 12/29/2006 - Disch - Home - MUKHERJEE KOUSTAV, MD
Discharge Condition - FUNCK, RN ERIKA at 12/29/2006 11:00
Discharge Patient: (Pending)
Administrative Discharge: (Pending)
Charting is Complete: (Pending)

Labs Ordered
(None)

X-Rays Ordered
06:21 12/29/2006 - Forearm (R) - STRATTON JENNIFER, MD
Order Placed By: MARQUES ANDREIA, MD
Prepare Patient for Xray - MARQUES ANDREIA, MD at 12/29/2006 06:24
Transport to X-ray - MARQUES ANDREIA, MD at 12/29/2006 06:24
Obtain Xray - HIS$ at 12/29/2006 08:43
Complete Xray - HIS$ at 12/29/2006 09:19
Review Results - MUKHERJEE KOUSTAV, MD at 12/29/2006 09:21
Order Information:
Pregnancy Status: PT Not Pregnant
Pregnancy Status Obtained thru: Patient history
Mode of Transportation: Stretcher
Priority: STAT
Patient name confirmed: Yes
Test confirmed: Yes
Clin DX/Pert HX/Phys Findings: 69 yo female s/p fall on right arm. with pain
06:22 12/29/2006 - Wrist 3vws (R) - STRATTON JENNIFER, MD
Order Placed By: MARQUES ANDREIA, MD
Prepare Patient for Xray - MARQUES ANDREIA, MD at 12/29/2006 06:25
Transport to X-ray - MARQUES ANDREIA, MD at 12/29/2006 06:25
Obtain Xray - HIS$ at 12/29/2006 08:34
Complete Xray - HIS$ at 12/29/2006 09:19
Review Results - MUKHERJEE KOUSTAV, MD at 12/29/2006 09:21
Order Information:
Pregnancy Status: PT Not Pregnant
Pregnancy Status Obtained thru: Patient history
Mode of Transportation: Ambulatory
Priority: STAT
Patient name confirmed: Yes
Test confirmed: Yes
Clin DX/Pert HX/Phys Findings: 69 yo female s/p fall on right arm with tenderness

Registration Info/Demographics

05:26 12/29/2006 - Registration Information - REG$
First Name: Ana
Last Name: Thomas
Chief Complaint: R ARM INJURY/PAIN
Date of Birth: 19370526
Sex: F
Medical Record Number: 200004371794
Social Security Number: 053-46-3979
Account Number: 000449139617
Zip Code: 11368
05:57 12/29/2006 - Registration Information - REG$
Chief Complaint: R ARM INJURY/PAIN
05:59 12/29/2006 - Registration Information - REG$
First Name: Anna
05:59 12/29/2006 - Registration Information - STEELE, BA MILTON
Arrival Time: 12/29/2006 05:26
Chief Complaint: R Arm injury/pain
Date of Birth: 05/26/1937

Provider/RN/Location Changes
05:26 12/29/2006 - Change Room - REG$
Change Room: Waiting Area Medicine ED
05:32 12/29/2006 - Change Room - MAURAIS, RN MARTIN
Change Room: Exam Room 17 Chair 1
05:34 12/29/2006 - Change Physician - ALCANA, RN ANDRES
ER Physician: STRATTON, JENNIFER B
Resident: Unassigned
Prim. Care Provider: Unassigned
Responsible Physician: STRATTON, JENNIFER B
05:34 12/29/2006 - Change Nurse - GUILLORY, RN KELLY
Primary Nurse: GUILLORY, RN, KELLY
Secondary Nurse: Unassigned
Responsible Nurse: GUILLORY, RN, KELLY
05:35 12/29/2006 - Change Nurse - SCOTT, RN KASI
Primary Nurse: SCOTT, RN, KASI
Secondary Nurse: Unassigned
Responsible Nurse: SCOTT, RN, KASI
06:02 12/29/2006 - Change Physician - MARQUES ANDREIA, MD
ER Physician: STRATTON, JENNIFER B
Resident: MARQUES, ANDREIA
Prim. Care Provider: Unassigned
Responsible Physician: STRATTON, JENNIFER B
07:12 12/29/2006 - Change Nurse - FUNCK, RN ERIKA
Primary Nurse: FUNCK, RN, ERIKA
Secondary Nurse: Unassigned
Responsible Nurse: FUNCK, RN, ERIKA
07:42 12/29/2006 - Change Room - FUNCK, RN ERIKA
Change Room: Xray Area (Adult Patient)
08:21 12/29/2006 - Providers - ABE MINAKO, MD
Physician 2: ABE, MINAKO
08:21 12/29/2006 - Change Physician - ABE MINAKO, MD
ER Physician: STRATTON, JENNIFER B
Resident: MARQUES, ANDREIA
Prim. Care Provider: Unassigned
Responsible Physician: ABE, MINAKO
08:30 12/29/2006 - Change Room - JULIEN, RN MARIE
Change Room: Exam Room 17 Chair 1

Follow Up
(None)

St. Lukes Emergency Department

1111 Amsterdam Avenue, NY, NY 10025
212-523-3335

St. Luke's Roosevelt
Continuum Health Partners, Inc.

Prescriptions Received: Acetaminophen w/codeine 30mg

Discharge Instructions Received: FRACTURED EXTREMITY, FRACTURED HAND, SPLINT CARE

Drug Instructions Received:

Referral:
CATALANO, LOUIS - 212-523-7590 in 5 days

I hereby acknowledge receipt of the instructions indicated above. I understand that I have had emergency treatment and that I may be released before all my medical problems are known or treated. I will arrange for follow-up care as instructed above.

****

Please follow up with Dr. Catalano next week. Come back to the hospital if you have any concerns. Take the pain medication for pain as needed.

****

Date/Time: 12/29/2006 10:57 Treating MD: STRATTON, JENNIFER B

Patient Signature: Anna Thomas

Account Number: 000449139617

Medical Record Number: 200004371794

I have removed IV access / heplock: ___YES ___NO ✓NOT APPLICABLE

RN/LPN/MD _____ Date: 12/29/06

I have explained the instructions and have given a copy to the patient.

St. Lukes Emergency Department

1111 Amsterdam Avenue, NY, NY 10025
212-523-3335

St. Luke's Roosevelt
Continuum Health Partners, Inc.

Signature: _____ Date: 12/29/06

Emergency Primary Nurse: FUNCK, RN, ERIKA

SA DNYRxPad.NY44315 | Rev 35 of 98 3/28/2006 N

3

OFFICIAL NEW YORK STATE PRESCRIPTION

ST LUKES-ROOSEVELT HOSPITAL CENTER

1000 TENTH AVENUE, NEW YORK, NY 10019 (212) 523-4000
1111-AMSTERDAM AVE., NEW YORK, NY 10025 (212) 523-4000

INSTITUTION DEA NUMBER (IF APPLICABLE) B S 3 7 8 9 5 5 6 SUFFIX

Imprinted Prescriber Name (Institutions Only)

Patient Name Anne Thomas Date 12/29/06

Address 99-10 60th Ave #5

City Corona State NY Zip 11368 Age 69 Sex M (F)

Rx

Percocet 5/325

sig: 1 - 11 tab po q 4-6 hr

Disp: #30

8

MAXIMUM DAILY DOSE (controlled substances only)

Prescriber Signature X K. Mj

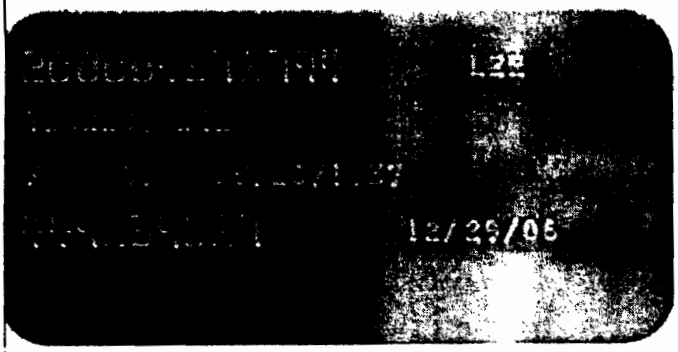
THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES 'daw' IN BOX BELOW

REFILLS None Refills:

PHARMACIST TEST AREA:

Dispense As Written

0F8BW8 45



St. Lukes Emergency Department
1111 Amsterdam Avenue, NY, NY 10025
212-523-3335

St. Luke's Roosevelt
Continuum Health Partners, Inc.

If you smoke, you are encouraged to quit in order to live longer, feel better, and heal faster. Quitting will lower your chance of heart attack, stroke, or cancer. The people you live with, especially children, will be healthier. Please contact the following numbers for additional information:

At St. Luke's: (212) 523-4410 At Roosevelt: (212) 523-6056

****

SPLINT CARE:

Your doctor has applied a splint to rest and protect your injury. Splints can be made of plaster, fiberglass, or metal; they are used to treat fractures, sprains, tendonitis, and and other injuries. Please keep your injury elevated to reduce swelling and pressure under your splint. If an elastic bandage has been used hold the splint, it can be loosened if you have increased swelling or pain.
Try to keep your splint clean and dry. They can be used for weeks if needed to treat serious sprains, or minor fractures. Do not put objects under your splint to scratch yourself. Call your doctor right away if you have:

- Increased pain or pressure around the injury.
- Numbness, tingling, or painful, cool toes or fingers.

Call your doctor for follow up care as recommended, especially if your splint becomes too soft or broken before you are healed.

FRACTURED EXTREMITY:

Your exam shows you have a broken bone. Broken bones (fractures) take many weeks to heal. The broken ends must be lined up correctly and kept perfectly still for proper healing. Please do not remove the splint, immobilizer, or cast that has been applied to treat your injury. This is the most important part of your treatment. Other measures to treat fractures include:

- Keep the injured limb at rest and elevated as recommended by your doctor. This will help reduce pain and swelling.
- Ice packs can be applied to your fracture site frequently for next 2-3 days.
- Pain medicine is often prescribed in the first days after a fracture.

Call your doctor or the emergency room at once if you notice increasing pain or pressure in the injured limb, or if it becomes cold, numb, or pale. Proper follow-up care is very important, so call your doctor for an appointment as soon as possible.

St. Lukes Emergency Department

1111 Amsterdam Avenue, NY, NY 10025
212-523-3335

St. Luke's Roosevelt
Continuum Health Partners, Inc.

Take-Home Instructions for the Patient

Patient's Name: Thomas, Anna **Date: 12/29/2006**
Medical Record Number: 200004371794 **Date of Service: 12/29/2006**
Diagnosis: Fx closed radius, head
Emergency Attending Physician: STRATTON, JENNIFER B
Emergency Resident Physician: MARQUES, ANDREIA
Emergency Primary Nurse: FUNCK, RN, ERIKA

PLEASE NOTE: The examination and treatment that you have received in the Emergency Department have been rendered on an emergency basis only and are not intended to be a substitute for or an effort to provide complete medical service. A follow-up doctor or facility is named below. It is important that you be checked again as recommended below and report any new or remaining problems at that time, because it is impossible to recognize and treat all elements of injury or illness in a single Emergency Department visit. In addition, if an X-Ray has been taken here, it has been read on a preliminary basis only, and a final review will be made by the Radiologist.

Call to arrange an appointment to see the following physician for follow-up care.

Referral:
CATALANO, LOUIS - 212-523-7590 in 5 days

****

Please follow up with Dr. Catalano next week. Come back to the hospital if you have any concerns. Take the pain medication for pain as needed.

****

When you call for an appointment, say that you were referred from this Emergency Department.

If you cannot see the above doctor and your condition worsens so that you require emergency treatment, come back to this department.

PLEASE TAKE THIS WITH YOU WHEN YOU SEE DOCTOR LISTED ABOVE

****

St. Lukes Emergency Department
1111 Amsterdam Avenue, NY, NY 10025
212-523-3335

St. Luke's Roosevelt
Continuum Health Partners, Inc.

FRACTURED HAND:

Your exam shows you have a fractured hand. Broken bones in the hand can be caused by crush injuries or from hitting objects with a fist. If the bones are in good position and the hand is properly immobilized and rested, these injuries will usually heal in about 6 weeks.
A cast or splint is usually applied to keep the fracture site from moving. Keep your hand elevated above the level of your heart as much as possible for the next 2-3 days until the swelling and pain are better. Please see your doctor or an orthopedic specialist for follow-up care within the next 10 days to make sure the fracture is beginning to heal properly. Call your doctor or the emergency room right away if you notice your fingers are cold or numb, or the pain of your injury is severe.

ELMHURST HOSPITAL CENTER — EMERGENCY SERVICE

DEMOGRAPHIC INFORMATION

REGISTRATION DATE AND TIME	VISIT DATE	VISIT SEQUENCE #	PATIENT ACCOUNT NO.	MEDICAL RECORD #
12/28/2006 05:1	12/28/06	999	38027316	2731646

PATIENT'S NAME (LAST-FIRST-M.I.)	PATIENT'S PHONE	M/S	SEX	DATE OF BIRTH	AGE
THOMAS ANNA	718-21[illegible]	M	F	05/26/1937	69Y

ADDRESS (NUMBER & STREET)	APT. NO.	CITY	STATE	ZIP CODE	RELIGION	SOCIAL SECURITY NO.
99-10 60TH AVENUE	5J	CORONA	NY	11368	SOP	093-44-[illegible]

PATIENT'S EMPLOYER	EMPLOYER'S ADDRESS (STREET & NO.)	EMPLOYER'S CITY	STATE	LIVES ALONE?	RACE
RETIRED					W

EMPLOYER'S PHONE	MOTHER'S FIRST NAME	CONT. VISIT	HMO SITE	ACCIDENT CODE	MODE OF ARRIVAL	AMB	PRECINCT	BADGE NO.
	MARIA			03	CAM			

NOTIFY	RELATIONSHIP	RELATION NAME (LAST-FIRST-M.I.)	RELATION BUSINESS PHONE
	S	THOMAS, [illegible] FLOYD	

RELATION ADDRESS (NUMBER & STREET)	APT.	RELATION CITY	STATE	REL. ZIP	RELATION HOME PHONE
99-10 60TH AVENUE		CORONA	NY	11368	718-210-93[illegible]

GUARANTOR'S NAME (LAST-FIRST-M.I.)	GUARANTOR'S RELATION	GUARANTOR'S ADDRESS (NUMBER & STREET)
THOMAS ANNA	SELF X\1	99-10 60TH AVENUE

APT.	GUARANTOR'S CITY	STATE	GUAR. ZIP	GUARANTOR'S PHONE	GUARANTOR'S EMPLOYER
5J	CORONA		11368	718-210-9350	RETIRED

GUARANTOR'S EMPLOYER ADDRESS (NUMBER & STREET)	GUAR. EMPLOYER'S CITY	STATE	GUAR. EMP ZIP	GUAR. EMPLOYER'S PHONE

F/C	CLINIC CODE	FEE SCALE	FEE AMOUNT	OTHER INS. PLAN	OTHER INS. GROUP NO.	OTHER POLICY NO.
Z	000		$14.79			059463979

BLUE CROSS I D GROUP NO.	B.C. SUFFIX	VERIFY?	UNION NAME	BILL AMOUNT
				$ 21[illegible]

PREFIX	MEDICARE NO.	SUFFIX	MEDICAID NO.	INTERVIEWED	THIS VISIT
			[illegible]194148H	ESC	

VISIT	PT TYPE	SERVICE PROVIDER NAME & SERVICE PROVIDER NUMBER
	E	

PRIMARY DX CODE	PRIMARY HCPCS CODE	SECONDARY DX CODE	SECONDARY HCPCS CODE

PROCEDURE CODE	PROCEDURE CODE	PROCEDURE CODE	PROCEDURE CODE	CLOSED BY:
.	.	.	.	

RECENT ED VISITS	RECENT HOSPITAL DISCHARGE	PENDING OPD APPOINTMENTS
9999		

CHIEF COMPLAINT:
ASSAULTED/PAIN TO RT WRIST/HIP

NOTES:
M40 Z53

NEEDS CONSENT/PT UNABLE TO SIGN

REQUEST FOR RADIOLOGY

X-RAY ORDER:

NAME

MR:

EXAM REQUESTED

INFORMATION DESIRED

HISTORY & PHYSICAL FINDINGS

LAB DATA

REQUESTED BY:

PRINT _____ M.D.

SIGNATURE _____ M.D.

BEEPER NUMBER

M.D. HOSP I.D. #

TECHNOLOGIST SIGNATURE	DATE OF EXAM	8 x 10	10 x 12	9.5 x 9.5	14 x 17	OTHER	X-RAY ROOM #

ROUTINE DIAGNOSTIC RADIOLOGY — TO BE COMPLETED BY RADIOLOGY STAFF

REV. 1/99 ELM 401

PATIENT NAME:

ORDERS

TIME	MD	ORDERS	ATURE	TIME

CONSULTS

SERVICE	TIME CALLED	TIME RESPONDED	TIME ARRIVED

SOCIAL WORK CONSULT

LABORATORY ORDERS

NAME

MR:

☐ CBC ☐ BCx ____ ☐ CARDIAC ENZYMES ☐ U/A

☐ SMA ____ ☐ T&C ____ ☐ VDRL ☐ URINE C&S

☐ LFT's ☐ T&H ☐ TOX SCREEN ☐ UCG

☐ β-HCG ☐ EKG ☐ ETOH ☐ GC/CHLAMYDIA

☐ ABG ☐ X-RAY ☐ PT/PTT

☐ OTHER: _____ MD SIGNATURE: _____

ELMHURST HOSPITAL EMERGENCY DEPARTMENT SERVICES

PATIENT NAME: [illegible] TINA 12/28/2005 [illegible] PM 2731648

Time Seen: Print MD Name:

☐ Translator Used ☐ Medical Record requested/reviewed ☐ FT ☐ Card ☐ Tr ☐ A ☐ B

HPI

cc

PMH

PMH:

P SURG Hx:

SOCIAL Hx:

FAMILY Hx:

MEDICATIONS:

ALLERGIES:

LMP:

LAST TETANUS:

ROS:

☐ Unable to obtain @ present due to patient's condition

☐ All other systems reviewed and negative or noncontributory

☐ Following abnormalities noted

VS

TIME	BP	PULSE	RR	TEMP	O2 SAT

PHYSICAL

RESIDENT/PA SIGNATURE: ID #: PRINT:

ORIG

PATIENT NAME:

CBC	CHEM	ABG	

X-RAY	EKG - 12 LEAD	OTHER:

TIME	MANAGEMENT/PROCEDURE NOTE:
	☐ Risks, benefits and alternatives of _____
	explained to patient and consent obtained

ATTENDING NOTE/ASSESSMENT:

	☐ Patient seen, examined and discussed with resident/PA

DIAGNOSIS: _____

☐ Admit To: _____ ☐ Transfer: _____

☐ T&R Condition: Stable / Improved ☐ AMA ☐ Elopement ☐ DOA/DIE - ME#: _____

ATTENDING SIGNATURE: _____ ID #: _____ PRINT: _____

FINAL

FDNY Prehospital Care Report

Station # | CAD # | Unit # | ☐ ALS | 712 .5

Today's Date | Arrived | En Route (82) | On Scene (84) | Patient Contact (Destination (85) | At Destination (86) | Available Service

1 8 / 8 / 06 | 1509 | 1539 | 1545 | 09

CALL INFO

Incident Address: 96-05 Queens Blvd | Apt Number | Driver's Shield #: 3150

Prior Treatment(s) / by whom | Police Agency | Shield # | Responded From: Patient's Home | CREW # 1 | CREW # 2 | Tech / Documentation Shield #: 3079

PATIENT INFO

Last Name: THOMAS | First Name: THOMAS ANNA 302-52-1602 | MI | ☐ Male ☑ Female | Weight (lb): 150

Street Address: 99-10 60 Ave ☐ Check this box if same as Incident Address ☐ Check if Patient is Homeless | 2731640 12/29/06 8-25/1 10/17 ER | Apt Number: 5J

City: Flushing | State: NY | Zip Code: 11368 | Social Security Number: 052-46-9779 | SSN UTO ☐

Age: 49 ☐ Days ☐ Months ☑ Years | Date of Birth: 05-26-1957 | Home Phone: 718-210-3350 | Emergency Contact / Emergency Contact Phone #

PRESENTING PROBLEM

Medical

- ☐ 10 Abdominal Pain
- ☐ 11 Airway Obstruction
- ☐ 12 Allergic Reaction
- ☐ 13 Altered Mental
- ☐ 14 Asthma
- ☐ 15 Behavioral Disorder
- ☐ 16 Cardiac Arrest
- ☐ 17 Cardiac Symptoms
- ☐ 18 Chest Pain
- ☐ 19 Cough
- ☐ 20 Cough W/Blood
- ☐ 21 CVA / Stroke
- ☐ 22 Dehydration
- ☐ 23 Depression
- ☐ 24 Diabetic Symptoms
- ☐ 25 Dizziness
- ☐ 26 Dyspnea / SOB
- ☐ 27 Fever
- ☐ 28 Flu Symptoms
- ☐ 29 Gen. Malaise
- ☐ 30 GI (Bleed)
- ☐ 31 GI (Constipation)
- ☐ 32 GI (Diarrhea)
- ☐ 33 Headache
- ☐ 34 Hyperthermia
- ☐ 35 Hyperventilation
- ☐ 36 Hypothermia
- ☐ 37 Med. Reaction
- ☐ 38 Nausea
- ☐ 39 Newly Born
- ☐ 40 Nose Bleed
- ☐ 41 GYN
- ☐ 42 OB-GYN (Comp.)
- ☐ 43 OB-In Labor
- ☐ 44 Obvious Death
- ☐ 45 Resp. Arrest
- ☐ 46 Resp. Failure
- ☐ 47 Seizure
- ☐ 48 Sickle Cell Crisis
- ☐ 49 Sore Throat
- ☐ 50 Syncope
- ☐ 51 Unconscious
- ☐ 52 Urinary Bleeding
- ☐ 53 Urination Problem
- ☐ 54 Vomiting
- ☐ 55 Vomiting Blood
- ☐ 56 Weakness
- ☐ 57 Post - Op Comp.
- ☐ 58 Infectious Disease / Public Health Risk
- ☐ 97 Not listed (*specify in Comments sect.*)
- ☐ 98 Unknown Medical
- ☑ 99 No Medical Prob.

Cause of Injury / Illness

- ☐ 10 Alcohol
- ☐ 11 Animal Bites
- ☐ 12 Blunt Force
- ☐ 13 Bicycle Accident
- ☐ 14 Collapse
- ☐ 15 Crush
- ☐ 16 Dom. Violence
- ☐ 17 Near Drowning
- ☐ 18 Drug
- ☐ 19 Electric Injury
- ☐ 20 Excessive Cold
- ☐ 21 Excessive Heat
- ☐ 22 Explosion
- ☐ 23 Fall
- ☑ 24 Fight / Assault
- ☐ 25 Fire / Scald
- ☐ 26 Foreign Object
- ☐ 27 Gun Shot
- ☐ 28 Haz Mat.
- ☐ 29 Lightning
- ☐ 30 Machinery
- ☐ 31 Med. Device Failure
- ☐ 32 MVA Off Road
- ☐ 33 MVA Traffic
- ☐ 34 Pedestrian Struck
- ☐ 35 Poisoning
- ☐ 36 Radiation Exp.
- ☐ 37 Railway Accident
- ☐ 38 Sexual Assault
- ☐ 39 Smoke Inhalation
- ☐ 40 Stabbing
- ☐ 41 Suffocate / Hypoxia
- ☐ 42 Susp. Child Abuse
- ☐ 43 Susp. Elder Abuse
- ☐ 44 Susp. Suicide
- ☐ 45 Water Accident
- ☐ 97 Not listed here (*specify in Comments*)
- ☐ 98 Unknown Cause
- ☐ 99 No Injuries

Body Matrix (Mark all that apply)

	Amputation	Bleeding	Burn	Dislocation	Fracture	Pain	Paralysis / Paresis	Swelling	Soft Tissue Injury
Head	☐	☐	☐	☐	☐	☐	☐	☐	☐
Face	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eye	☐	☐	☐	☐	☐	☐	☐	☐	☐
Neck	☐	☐	☐	☐	☐	☐	☐	☐	☐
Chest	☐	☐	☐	☐	☐	☐	☐	☐	☐
Back (Upper)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Back (Lower)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Shoulder/Up Arm	☐	☐	☐	☐	☐	☐	☐	☐	☐
Elbow / Forearm	☐	☐	☐	☐	☐	☐	☐	☐	☐
Wrist	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hands / Fingers	☐	☐	☐	☐	☐	☑	☐	☐	☐
Abdomen (Upper)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Abdomen (Lower)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pelvis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genitals	☐	☐	☐	☐	☐	☐	☐	☐	☐
Upper Leg	☐	☐	☐	☐	☐	☐	☐	☐	☐
Knee	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lower Leg	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ankle / Foot	☐	☐	☐	☐	☐	☐	☐	☐	☐

ASSESSMENT

Elapsed Time	Systolic B/P	Diastolic		Pulse	Respir.	Pain (0-10)
05	164	98	P ☐	94	18	07

SPO2 | Temperature | GCE | GCV | GCM | GST | Patient Status: ☐C ☐P ☐U ☑S

4 5 6 15

Breathing
- Quality: ☑ Normal ☐ Labored ☐ Shallow ☐ Irregular
- Lung Sounds (L / R): ☑ Clear ☑ | ☐ Rales ☐ | ☐ Wheeze ☐ | ☐ Rhonchi ☐ | ☐ Diminish ☐ | ☐ Absent ☐

Circulation (skin)
- Color: ☑ Normal ☐ Cyanotic ☐ Pale ☐ Flush ☐ Jaundice
- Temp.: ☑ Normal ☐ Hot ☐ Cool ☐ Cold
- Cond.: ☑ Normal ☐ Diaphor. ☐ Moist ☐ Dry ☐ Rash
- Radial Pulse (A): ☑ Present ☐ Absent
- Cap. Refill (P): ☐ <= 2 Sec ☐ > 2 Sec

Pupils (L / R): ☑ Reacts ☑ | ☐ Sluggish ☐ | ☐ Unreactive ☐ | ☐ Dilated ☐ | ☐ Constricted ☐

Mental Status: ☑ A ☐ V ☐ P ☐ U

Elapsed Time	Systolic B/P	Diastolic		Pulse	Respir.	Pain (0-10)
12	168	98	P ☐	92	18	07

Breathing
- Quality: ☑ Normal ☐ Labored ☐ Shallow ☐ Irregular
- Lung Sounds (L / R): ☑ Clear ☑ | ☐ Rales ☐ | ☐ Wheeze ☐ | ☐ Rhonchi ☐ | ☐ Diminish ☐ | ☐ Absent ☐

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Mental Status: ☐ A ☐ V ☐ P ☐ U

Elapsed Time	Systolic B/P	Diastolic		Pulse	Respir.	Pain (0-10)
			P ☐			

TREATMENT

- ☐ CPR
- ☐ AED Application — Crew # ☐1 ☐2
- ☐ NSI
- # Shocks Delivered

- ☐ Airway Maintenance
- ☐ Modified Jaw Thrust
- ☐ Oral Airway
- ☐ Nasal Airway
- ☐ Mouth to Mask
- ☐ Abd./Chest Thrust
- ☐ Suction

- ☐ Cervical Collar — SSID: ☐ Vest ☐ SSB
- ☐ Long SID
- ☐ Head Immobilizer
- ☐ Rapid Extrication
- Splint: ☐ Fixation ☐ Traction
- ☐ Sling / Swathe

- ☐ Pressure Point
- ☐ Pressure Dressing
- ☐ Wound Dressing
- ☐ Elevation
- ☐ Irrigation
- ☑ Cold Application
- ☐ Patient Warming
- ☐ Burn Care
- ☐ Induced Vomiting

Restrained by: ☐ PD ☐ EMS

- ☐ Nasal Cannula
- ☐ Non-Rebreather
- ☐ Bag Valve Mask
- ☐ Nebulizer

Oxygen L / M

- ☐ Baby
- APGAR - Initial | 5 min
- ☐ Placenta Delivered

ALS Crew Only

- ☐ ALS Assessment
- ☐ Magill Forceps
- ☐ Endotracheal Tube — Crew 1 Attempts | Crew 2 Attempts
  - Tube Size | S | S ☐ UTO ☐
- ☐ Secondary ETT Verification

- ☐ Cricothyrotomy — Crew # ☐1 ☐2
- ☐ Needle Decompression — L ☐ R ☐ — Crew # ☐1 ☐2
- ☐ NG Tube — Crew # ☐1 ☐2

- ☐ I.V ☐ I.O ☐ S. Lock — Crew 1 Attempts | Crew 2 Attempts
  - Gauge | S | S ☐ UTO ☐
- ☐ 2nd I.V — Crew 1 Attempts | Crew 2 Attempts
  - Gauge | S | S ☐ UTO ☐

Elapsed Time	Crew	Treatment #	Med #	Dose	Measure #	Route #	Use #	Total Use	Rhythm #	Condition	Comments

PATIENT PROBLEM ASSESSMENT FLOWCHART

Months / Years

Medical

- 10 Abdominal Pain
- 11 Airway Obstruction
- 12 Allergic Reaction
- 13 Altered Mental
- 14 Asthma
- 15 Behavioral Disorder
- 16 Cardiac Arrest
- 17 Cardiac Symptoms
- 18 Chest Pain
- 19 Cough
- 20 Cough W/Blood
- 21 CVA / Stroke
- 22 Dehydration
- 23 Depression
- 24 Diabetic Symptoms
- 25 Dizziness
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- 14 Collapse
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- 19 Electric Injury
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Body Matrix

(Mark all that apply)

	Amputation	Bleeding	Burn	Dislocation	Fracture	Pain	Paralysis / Paresis	Swelling	Soft Tissue Injury
Head									
Face									
Eye									
Neck									
Chest									
Back (Upper)									
Back (Lower)									
Shoulder/Up Arm									
Elbow / Forearm									
Wrist									
Hands / Fingers						☑			
Abdomen (Upper)									
Abdomen (Lower)									
Pelvis									
Genitals									
Upper Leg									
Knee									
Lower Leg									
Ankle / Foot									

Assessment

Elapsed Time	Systolic B/P	Diastolic		Pulse		Respir.	Pain (0-10)
05	164	98	P ☐	94		13	07

SPO2	Temperature	GCE	GCV	GCM	GST	Patient Status
		4	5	6	15	☐C ☐P ☐U ☑S

Breathing

Quality: ☑ Normal ☐ Labored ☐ Shallow ☐ Irregular

Lung Sounds: L / R — ☑ Clear ☑ ☐ Rales ☐ ☐ Wheeze ☐ ☐ Rhonchi ☐ ☐ Diminish ☐ ☐ Absent ☐

Circulation (skin)

Color: ☑ Normal ☐ Cyanotic ☐ Pale ☐ Flush ☐ Jaundice

Temp.: ☑ Normal ☐ Hot ☐ Cool ☐ Cold

Cond.: ☑ Normal ☐ Diaphor. ☐ Moist ☐ Dry ☐ Rash

Radial Pulse (A): ☑ Present ☐ Absent

Cap. Refill (P): ☐ <= 2 Sec ☐ > 2 Sec

Pupils

L / R: ☑ Reacts ☑ ☐ Sluggish ☐ ☐ Unreactive ☐ ☐ Dilated ☐ ☐ Constricted ☐

Mental Status

☑A ☐V ☐P ☐U

Elapsed Time	Systolic B/P	Diastolic		Pulse		Respir.	Pain (0-10)
12	168	98	P ☐	92		18	07

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Pupils

L / R: ☑ Reacts ☑ ☐ Sluggish ☐ ☐ Unreactive ☐ ☐ Dilated ☐ ☐ Constricted ☐

Mental Status

☐A ☐V ☐P ☐U

Elapsed Time	Systolic B/P	Diastolic		Pulse		Respir.	Pain (0-10)
			P ☐				

Treatment

- ☐ CPR — Crew # ☐1 ☐2
- ☐ AED Application — Crew # ☐1 ☐2
  - ☐ NSI
  - # Shocks Delivered
- ☐ Airway Maintenance
- ☐ Modified Jaw Thrust
- ☐ Oral Airway
- ☐ Nasal Airway
- ☐ Mouth to Mask
- ☐ Abd./Chest Thrust
- ☐ Suction
- ☐ Cervical Collar — SSID: ☐ Vest ☐ SSB
- ☐ Long SID
- ☐ Head Immobilizer
- ☐ Rapid Extrication — Splint: ☐ Fixation ☐ Traction
- ☐ Sling / Swathe
- ☐ Pressure Point
- ☐ Pressure Dressing
- ☐ Wound Dressing
- ☐ Elevation
- ☐ Irrigation
- ☑ Cold Application
- ☐ Patient Warming
- ☐ Burn Care
- ☐ Induced Vomiting

Restrained by: ☐ PD ☐ EMS

- ☐ Nasal Cannula
- ☐ Non-Rebreather
- ☐ Bag Valve Mask
- ☐ Nebulizer

Oxygen L / M

- ☐ Baby
- APGAR - Initial — 5 min
- ☐ Placenta Delivered

ALS Crew Only

- ☐ **ALS Assessment**
- ☐ Magill Forceps
- ☐ Endotracheal Tube — Crew 1 Attempts / Crew 2 Attempts — S / S UTO
  - Tube Size
- ☐ Secondary ETT Verification
- ☐ Cricothyrotomy — Crew # ☐1 ☐2
- ☐ Needle Decompression — L ☐ R ☐ — Crew # ☐1 ☐2
- ☐ NG Tube — Crew # ☐1 ☐2
- ☐ I.V ☐ I.O ☐ S. Lock — Crew 1 Attempts / Crew 2 Attempts — S / S UTO
  - Gauge
- ☐ 2nd I.V. — Crew 1 Attempts / Crew 2 Attempts — S / S UTO
  - Gauge

Flowchart

Elapsed Time	Crew	Treatment #	Med #	Dose	Measure #	Route #	Use #	Total Use	Rhythm #	Condition	Comments

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712 15

Narrative History: Key Words - (Onset, Provokes, Quality, Radiates, Severity, Position, Changes En Route, Medications)

PMH: ☐ Asthma ☐ Chronic Renal Failure ☐ Cardiac ☒ Diabetes ☐ Frail / Debilitated ☒ Hypertension ☐ IV Drug Use ☐ Seizure Disorder ☐ Tracheostomy
☐ Amputee ☐ Cancer ☐ COPD ☐ CVA / Stroke ☐ Dialysis ☐ HIV / AIDS ☐ Incontinent ☐ Psychiatric Hx. ☐ Substance Abuse ☐ Tuberculosis

Special Conditions: ☐ Bed Confined ☐ Non-Ambulatory ☐ Required Stretcher ☐ Valid DNR

Allergies: ☒ No known allergies PMH = high cholesterol

Medications: ☐ Unknown [illegible]

Obvious Death: ☐ Decomposition ☐ Dependent Lividity ☐ Rigor Mortis ☐ Mortal Injury

Cardiac Arrest Information

Witnessed By: ☐ PD ☐ CFR / EMS ☐ Other

ROSC: ☐ PD ☐ CFR / EMS ☐ Other

CPR was started by: ☐ Bystander ☐ Family ☐ PD ☐ CFR ☐ EMS ☐ Medical

Minutes Since: Arrest / CPR Started / CPR Stopped

AED was used by: ☐ PD ☐ CFR ☐ EMS ☐ Other

Minutes Since: 1st AED Shock

NARRATIVE HISTORY & COMMENTS

[illegible handwritten narrative] ... was ... to the floor by a ramp ... and pain to (R) wrist ... [illegible] ... for evaluation.

Chief Complaint: (R) wrist pain

Have the patient's symptoms appeared or gotten worse in the last 72 hours? ☒ Yes ☐ No

Presumptive Diagnosis: STI 2° fight [illegible]

Continuation Form ☐

OLMC

Time of Contact	OLMC Physician	Reason For Contact	OLMC Terminate Time	ED Chart Number
		☐ RMA ☐ Consult ☐ Orders ☐ Transport Decision ☐ Onscene Triage		

Crew #	C.S. Administered By - Signature	Witness Signature / Title	Amount Wasted	# Vials Used	OLMC Physician	URN	SO
			.			-	☐
			.			-	☐

PAYER INFO

Insurance Company Name

Policy Number

Group Number

Insurance Related Information
☐ Auto Insurance ☐ Self Pay
☐ Private Insurance

Medicare # 053463979A

Medicaid #

Work related? ☐

(1) PATIENT INFORMATION DISCLOSURE AND ASSIGNMENT OF CLAIM: I acknowledge that I have been given the Notice of Privacy Practices and Patient Information Release/Assignment of Claim, set forth on the Patient Copy of this Prehospital Care Report and have read or been informed of their contents, including the purposes for which my protected health care information will be shared, and my responsibility for any charges for services not covered by my insurance or found to be medically unnecessary.

I hereby authorize, for myself or my dependent(s), the release of medical and other information for the purposes specified, including treatment and billing. I further authorize and assign payment of Medicare and any other authorized benefits to the NYC Fire Department.

(1) Information Release Patient / Auth. Rep. Signature: X [illegible]

☐ Patient Unable to Sign ☐ Patient Refused to Sign

(2) OUT OF AREA TRANSPORT / DIVERSION: I request to be transported to a hospital that is more than 10 minutes from the closest appropriate hospital, or that is on diversion status. I have been advised and understand that I may experience delays in my care that may imperil my health or result in death.

☐ Patient Unable to Sign ☐ Patient Refused to Sign Hospital Requested:

(2) Out of Area Transport Patient Signature

(3) RELEASE/REFUSAL OF MEDICAL ASSISTANCE (RMA): I have been advised and I understand that I require medical assistance, and will be transported to a hospital of my choice, and that my refusal to accept such medical assistance may imperil my health or result in death, but I nonetheless refuse to accept the medical assistance. I agree to assume all risks, consequences and costs of my decision not to accept such care, and I release the provider of ambulance service, and its employees, agents and independent contractors, from any liability arising from my decision.

☐ Pre-hospital care refused: ☐ Transportation to hospital refused ☐ Patient Unable to Sign ☐ Patient Refused to Sign

List care refused:

(3) RMA Patient Signature

RMA Witness Name / Signature

Lights / Siren — Conditions Causing Delay — Seat Belt Use

NARRATIVE & COMMENTS

Chief Complaint: [illegible]

Have the patient's symptoms appeared or gotten worse in the last 72 hours? ☒ Yes ☐ No

Presumptive Diagnosis: STEMI [illegible]

Continuation Form ☐

OLMC

Time of Contact	OLMC Physician	Reason For Contact	OLMC Terminate Time	ED Chart Number
		☐ RMA ☐ Consult ☐ Orders ☐ Transport Decision ☐ Onscene Triage		

Crew #	C.S. Administered By - Signature	Witness Signature / Title	Amount Wasted	# Vials Used	OLMC Physician	URN	
			.			-	SO ☐
			.			-	SO ☐

PAYER INFO

Insurance Company Name

Policy Number

Group Number

Insurance Related Information
☐ Auto Insurance ☐ Self Pay
☐ Private Insurance

Medicare # 253463979A

Medicaid #

Work related? ☐

(1) PATIENT INFORMATION DISCLOSURE AND ASSIGNMENT OF CLAIM: I acknowledge that I have been given the Notice of Privacy Practices and Patient Information Release/Assignment of Claim, set forth on the Patient Copy of this Prehospital Care Report and have read or been informed of their contents, including the purposes for which my protected health care information will be shared, and my responsibility for any charges for services not covered by my insurance or found to be medically unnecessary.

I hereby authorize, for myself or my dependent(s), the release of medical and other information for the purposes specified, including treatment and billing. I further authorize and assign payment of Medicare and any other authorized benefits to the NYC Fire Department.

(1) Information Release Patient / Auth. Rep. Signature: X

☐ Patient Unable to Sign ☐ Patient Refused to Sign

(2) OUT OF AREA TRANSPORT / DIVERSION: I request to be transported to a hospital that is more than 10 minutes from the closest appropriate hospital, or that is on diversion status. I have been advised and I understand that I may experience delays in my care that may imperil my health or result in death.

(2) Out of Area Transport Patient Signature

☐ Patient Unable to Sign ☐ Patient Refused to Sign Hospital Requested:

(3) RELEASE/REFUSAL OF MEDICAL ASSISTANCE (RMA): I have been advised and I understand that I require medical assistance, and will be transported to a hospital of my choice, and that my refusal to accept such medical assistance may imperil my health or result in death, but I nonetheless refuse to accept the medical assistance. I agree to assume all risks, consequences and costs of my decision not to accept such care, and I release the provider of ambulance service, and its employees, agents and independent contractors, from any liability arising from my decision.

☐ Pre-hospital care refused: ☐ Transportation to hospital refused

List care refused:

☐ Patient Unable to Sign ☐ Patient Refused to Sign

(3) RMA Patient Signature

RMA Witness Name / Signature

SAFETY

Lights / Siren: ☒ To Scene (63) ☐ To Destination (82)

Conditions Causing Delay

	Traffic	Weather	Crowd	Scene Unsafe	Bad Address	Difficult Location	Extrication	Elevator	Building Access	Door Barrier	Distance To Pt.	Awaiting Escort	Vehicle Mech.
To Scene	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
To Patient	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
To Hospital	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Seat Belt Use: ☐ Lap Belt ☐ Shoulder Belt
Car Seat: ☐ Front Facing ☐ Side Facing ☐ Rear Facing

Airbags Deployed: ☐ Steering Wheel ☐ Passenger Dash ☐ Driver Door ☐ Passenger Door ☐ Other

Patient Safety Equip: ☐ Eye Protection ☐ Helmet ☐ Personal Flotation ☐ Protective Clothing ☐ Protective Gear

DISPOSITION

Removed to Vehicle By: ☒ Chair ☐ Walked ☐ Carried ☐ Scoop Stretcher ☐ Flat ☐ Stretcher ☐ Met at Ambulance

Transport From: ☐ Residence (Home) ☒ Scene of Accident or Acute Event ☐ Residential, Custodial Facility ☐ Skilled Nursing Facility (SNF) ☐ Inter-facility
Transport From Code:

Transport Position: ☐ Supine ☐ Sitting ☐ Shock ☒ Semi / Full Fowlers ☐ Left Lateral Recumbent ☐ Restrained

Pt Transported In Vehicle: #of Patients Transported: 1 Transport Miles: 02
Hospital Destination: 32

Hospital Selection: ☒ Nearest Facility ☐ Patient / Family Choice ☐ Specialty Referral ☐ Hospital Diversion
Diverted From code:

Pt Not Transported In This Vehicle: ☐ Assisted in Transport With Unit # ☐ RMA ☐ Pronounced, NOT Transported ☐ Onscene Triage ☐ Transferred Care To Unit # ☐ Other

ADMIN

Hospital Receiving Agent Signature | FDNY Code | Qty | Supply Code | Qty | Supply Code | Technician Signature

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28 Dec 06 1619

Elmhurst Hospital Center
ED Patient Without Medical Record Number Notification

Pt Name	MRN	Age	Birthdate	Sex	SSN
THOMAS, ANNA		69	05/26/1937	F	

Urgent **Urgent** **Urge**

Visit Date/Time: 12/28/06 1619
ED Service: SURG (Team B)
ED Triage Class: Urgent
Chief Complaint: PAIN TO RIGHT WRIST, S/P ASSAULTED, HIGH BP, NON-COMPLIANT WITH MEDS
Location: [redacted] Broom
Information Source: EMS
Language Spoken: ENGLISH
Comment:

Printed At: 12/28/2006 1619
By: Walton,Fe G., RN

Clinical Information

Med Allergy **N - N**
Other Allergy **N - N**

Additional Meds: AMAYRL,INSULIN,HCTZ,ATENOLOL,ACUPRIL,GLYCETTE,NORVASC, ECOT
Past Medical Hx: HTN
NIDDM/DDM

Pulse: **99**
Resp: **18**
BP: **231/96**
Temp: **97.6**
Wt:

MRN 7316446

Current Pain? Yes
Pain in Last 2 Wks? No
Location: RIGHT WRIST
Intensity: 7-9 severe pain,
Description: ACHING
Comment: PT WAS ASSAULTED AND FELL, -LOC
LMP: NA
Nursing Assessment: PAIN TO RIGHT WRIST, S/P ASSAULTED, -LOC
Domestic Violence: No
02 Sat: 100 %
FS Glucose: 333 mg/dL
Initial Treatment: Diabetes
Presented To MD: DUQUE

Nurse _____ Date 12/28/06

Thomas anna

CONTINUATION ER NURSES' RECORD
TEAM ASSESSMENT & REASSESSMENT

DATE: TIME: SHIFT: I II III

PROPERTY VALUABLE LIST: Nurse Initials: ☐ To Admitting Office ☐ With Patient ☐ Family:

ADDRESSOGRAPH PLATE (ID LABEL)

ON-GOING VITAL SIGNS

TIME	TEMP/ MODE	B/P	PR	RR	O_2 SAT	PAIN Use scale
1800		183/76	76	17	100	3 4

ON-GOING THERAPY/MONITORING

CARDIAC MONITOR
EKG Rhythm: _____

IV THERAPY: _____ @ _____ cc/hr
ACCESS: ☐ Angio Cath ☐ Med lock
SITE _____
☐ No redness, no infiltration

OXYGEN THERAPY
Type: ☐ Nonrebreather FiO2: _____
☐ Nasal Cannula FiO2: _____
☐ Others: _____ FiO2: _____

☐
☐

PROCEDURES/DIAGNOSTIC TESTS

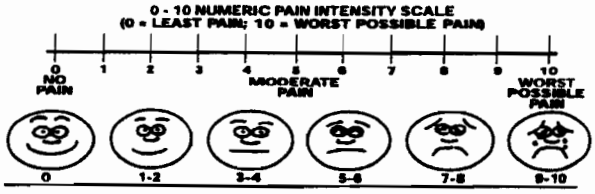
Time Done		Time Done	
	☐ Straight Catheterization		☐ CT Scan ☐ Head ☐ Abdomen ☐ Others: _____
	☐ Chest X-ray Radiology Portable		
	☐ C-Spine		☐ 12 LEAD EKG
	☐ Pelvis		☐
	☐ Sonogram		☐
	☐		☐
	☐		☐
	☐		☐

PROGRESS NOTES
Assessment and ongoing treatment and patient response

1800 Received pt B stretcher A+Ox3 resp wnl. Staff was accidentally pushed onto wall hitting R arm no bruising or deformity noted. Pt denies any other complaints pending MD evaluation. Marvin RN

REPEAT LABS

	Time and Initial
☐ CPK Time due # 2 _____	/
☐ CPK Time due # 3 _____	/
☐ Troponin Time due # 2 _____	/
☐ HCT Spun	/
☐ PT/PTT	/
☐	/
☐	/
☐	/



CONTINUATION ER NURSES' RECORD
TEAM ASSESSMENT & REASSESSMENT

DATE: TIME: SHIFT: I II III

PROPERTY VALUABLE LIST: ☐ To Admitting Office ☐ Family: ________________
Nurse Initials: ____________ ☐ With Patient

ADDRESSOGRAPH PLATE (ID LABEL)

ON-GOING VITAL SIGNS

TIME	TEMP/ MODE	B/P	PR	RR	O_2 SAT	PAIN Use scale

ON-GOING THERAPY/MONITORING

CARDIAC MONITOR
EKG Rhythm: ________________

OXYGEN THERAPY
Type: ☐ Nonrebreather FiO2: __________
☐ Nasal Cannula FiO2: __________
☐ Others: ______ FiO2: __________

IV THERAPY: ________ @ ______ cc/hr
ACCESS: ☐ Angio Cath ☐ Med lock
SITE ____________________
☐ No redness, no infiltration

☐
☐

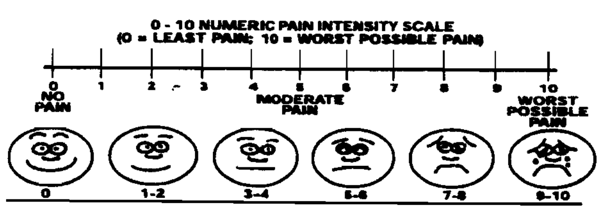
PROCEDURES/DIAGNOSTIC TESTS

Time Done		Time Done	
	☐ Straight Catheterization		☐ CT Scan ☐ Head ☐ Abdomen ☐ Others: ________
	☐ Chest X-ray Radiology Portable		
	☐ C-Spine		☐ 12 LEAD EKG
	☐ Pelvis		☐
	☐ Sonogram		☐
	☐		☐
	☐		☐
	☐		☐

PROGRESS NOTES
Assessment and any changes in treatment and patient responses

REPEAT LABS

	Time sent/initial
☐ CPK Time due # 2 ____________	/
☐ CPK Time due # 3 ____________	/
☐ Troponin Time due # 2 ________	/
☐ HCT Spun	/
☐ PT/PTT	/
☐	/
☐	/
☐	/



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